APPLICATION TO ADD A BENEFICIARY

Please complete this application form and return it to us, either by email or post. See our contact information at the end of this form. Please complete this form in BLOCK CAPITALS.

APPLICANT DETAILS

Policy Holders Name	
Policy Number	

HOW WE USE YOUR INFORMATION

We will collect, use, store, and disclose your personal information, including sensitive information (in particular, information relating to your medical history and any medical treatment you may have or have had), in accordance with relevant data protection legislation. We collect and will use your personal information, including sensitive information, for the purpose of carrying out our obligations under this plan. We may share your information, including sensitive information, with other Cigna companies and authorised healthcare providers, where necessary to carry out our obligations under this plan. This statement also applies to personal information of any beneficiaries detailed on this application form. You have the right to request a copy of your personal information held by us, and beneficiaries under your policy have the right to request a copy of personal information we hold about them. We may charge a fee to provide this information.

BENEFICIARY 1 DETAILS

Title		First Name		Other Initials		Surname	
Relationship to policyholder				Gender (please tick)	Male ☐	Female ☐	
Date of birth (DD/MM/YYYY)				Occupation			
Nationality (What is the nationality of the primary passport that you hold?)							
Location (The country in which you live/will live for the majority of your time for the period of cover)							
Height: Feet		Inches		Centimetres		**Weight:** Stones	Pounds	Kilogrammes
Has the beneficiary smoked, or used tobacco or nicotine replacement products in the last 12 months?					Yes ☐	No ☐	
If **Yes**, how many per day?	Less than 20 per day ☐		20 or more per day ☐		Other		
If the beneficiary is less than 90 days old:							
Was the beneficiary born as a result of fertility treatment?	Yes ☐	No ☐					
Was the beneficiary born to a surrogate or adopted?	Yes ☐	No ☐					
Was the beneficiary born premature?	Yes ☐	No ☐					
If Yes, at how many weeks of pregnancy were they born?							

BENEFICIARY 2 DETAILS *(if required)*

Title		First Name		Other Initials		Surname	
Relationship to policyholder				Gender (please tick)	Male ☐	Female ☐	
Date of birth (DD/MM/YYYY)				Occupation			
Nationality (What is the nationality of the primary passport that you hold?)							
Location (The country in which you live/will live for the majority of your time for the period of cover)							
Height: Feet		Inches		Centimetres		**Weight:** Stones	Pounds	Kilogrammes
Has the beneficiary smoked, or used tobacco or nicotine replacement products in the last 12 months?					Yes ☐	No ☐	
If **Yes**, how many per day?	Less than 20 per day ☐		20 or more per day ☐		Other		
If the beneficiary is less than 90 days old:							
Was the beneficiary born as a result of fertility treatment?	Yes ☐	No ☐					
Was the beneficiary born to a surrogate or adopted?	Yes ☐	No ☐					
Was the beneficiary born premature?	Yes ☐	No ☐					
If Yes, at how many weeks of pregnancy were they born?							

DECLARATION FOR ALL CUSTOMERS

Please note - We require you to disclose every aspect of the medical history for the beneficiary. This includes telling us about any changes to any medical conditions, treatment or medication and any outstanding, ongoing or repeat medical tests that have been suggested.

If any applicant fails to inform us about a condition which we reasonably believe to have existed prior to the policy initial start date or the effective date of the change to the policy (whether the condition was already present, the applicant had symptoms, or taken advice from a medical practitioner); this could (subject to local law and regulation) result in us reducing the amount of any claims payment, which the applicant is due or in refusing to pay a claim or claims related to such condition altogether.

You warrant and represent that you have each covered person's consent to disclose the personal information, including the sensitive personal information (e.g. medical information) contained in this form to us. You confirm that each covered person is aware of their duty to take reasonable care to answer questions accurately, honestly, completely and to the best of their knowledge.

(Please note that if you are declaring the above on another person's behalf, it is your obligation to keep evidence of the consent you are providing hereto of your covered family members' actual declarations and consents.)

Consent obtained (internal use only)	☐	**Date**	
Policy Holder's Signature		**Date**	

CONFIDENTIAL HEALTH QUESTIONNAIRE

You now need to provide information about the medical history of the beneficiary. If you tick Yes to a question, please provide full details overleaf.

Once you've done this we can finalise your application. It may help to have any relevant medical documentation to hand when you are filling out this form. Depending on the medical history, we might need some further information before we can finalise cover.

Please read the following questions very carefully. Please take reasonable care to answer all questions honestly and fully. Careless misrepresentation could result in Cigna reducing the amount of any claims proportionately; whereas deliberate or reckless misrepresentation could result in Cigna rejecting claims, and/or cancelling cover. If you need help completing your application, please contact us.

If you are unsure about the answer to any question you should make the enquiries necessary to allow you to provide an accurate answer.

MEDICAL QUESTIONS

	Has any beneficiary received treatment, test or investigations for, or been diagnosed with, or had any symptoms of:	(tick if yes)
1	**Diabetes and other endocrine (glandular) disorders** e.g. any thyroid disorder, weight problems, gout, pituitary or adrenal gland conditions?	☐
2	**Heart or circulatory disorders** e.g. chest pain, heart attack, high blood pressure, vascular disease, coronary artery disease, angina, irregular heartbeat, aneurysm or heart murmur.	☐
3	**Cancer, tumours or growths** including polyps, cysts or breast lumps.	☐
4	**Muscle or skeletal problems** e.g. back pain, whiplash, arthritis, joint pain or problems, gout, fractures, cartilage, tendon or ligament problems.	☐
5	**Asthma, allergies, breathing or respiratory disorders** e.g. chest infections, pneumonia, bronchitis, shortness of breath, rhinitis, TB, emphysema or chronic obstructive pulmonary disease.	☐
6	**Gall bladder, stomach, intestinal, gastric or liver problems** e.g. irritable bowel disease, colitis, Crohn's disease, gastric or peptic ulcers, reflux, indigestion, heartburn, gall stones, hernia, haemorrhoids or hepatitis.	☐
7	**Brain or neurological disorders** e.g. multiple sclerosis, epilepsy or seizures, stroke, migraines, recurring or severe headaches, meningitis, shingles or nerve pain.	☐
8	**Skin problems** e.g. eczema, acne, moles, rashes, allergic reactions, cysts, dermatitis or psoriasis	☐
9	**Blood, infective or immune disorders** e.g. high cholesterol, anaemia, malaria, HIV or systemic lupus erythematosus.	☐
10	**Urinary or reproductive disorders** e.g. urinary tract infections, kidney problems, fibroids, painful, irregular or heavy periods, fertility problems, polycystic ovarian syndrome, endometriosis, testicular or prostate problems.	☐
11	**Anxiety, depression, psychiatric or mental health issues** including eating disorders, post-traumatic stress disorder, alcohol or drug issues.	☐
12	**Ear, nose, throat, eye or dental problems** e.g. ear infections, sinus problems, tonsils and adenoids, cataracts, glaucoma, wisdom teeth problems.	☐
	Please also answer the following questions:	
13	Does any beneficiary have any illness, condition or symptom not already mentioned? Please include details of any known or suspected issues whether or not medical advice has been sought or a diagnosis reached.	☐
14	Does any beneficiary take any medication, receive any treatment of any kind or expect to have a review or follow up for any current or past medical problem not already mentioned?	☐

ADDITIONAL HEALTH INFORMATION

Please tell us more if you have answered 'Yes' to any questions in Medical Questions. If you are unsure if any details are relevant please include them anyways. If you run out of space, please use separate sheet.

Question Number	Is this information relevant to Beneficiary 1, Beneficiary 2 or both?	What is the name of the illness or medical problem. Where applicable state the area of the body affected?(e.g. left arm, right foot)	When did the symptoms occur and when did you last have symptoms?	What treatment was provided? (Include details of medication and dates of when treatment started and ended)	What is the current status of the illness or medical problem? (E.g. ongoing, complete, recovery, recurrent or likely to recur.)

SPACE FOR ADDITIONAL INFORMATION

Please return your fully completed form to:

Postal Address:
Customer Service Team
Cigna Global Health Options
1 Knowe Road
Greenock
PA15 4RJ
United Kingdom

Email Address:
cgi@cigna.com

Together, all the way.℠